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ABSTRACT

This document presents the annual report and recommendations of Minnesota's Medical Education and Research Costs (MERC) Trust Fund, a program that provides funding for the clinical training of selected medical professions through compensating the costs of training provided in a clinical teaching environment. State general funds and health care access funds are combined with matching federal funds and are distributed to teaching programs on the basis of the number of eligible trainees and the average cost of clinical training. Recent legislative changes also authorize transfer of the medical education component of the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC) capitation rates to the MERC Trust Fund. Recommendations address the following concerns: an allocation formula for distribution of medical education funds from the PMAP and PGAMC programs; (2) additional broad-based funding sources; and (3) feasibility of including a carve-out of current Minnesota care capitation rates allowed for medical education to the Trust Fund. Future issues briefly discussed include the targeting of funds in accordance with the purpose of MERC and appropriate staffing and support. Appendices include texts of relevant Minnesota laws, lists of MERC committee members, and a sample MERC Web home page. (DB)

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Medical Education and Research Costs (MERC)

Annual Report on Program Implementation and Recommendations

April 1998

Minnesota Department of Health
Health Economics Program

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Medical Education and Research Costs (MERC)

Annual Report on Program Implementation and Recommendations

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Executive Summary

The Medical Education and Research Costs (MERC) Trust Fund was established in 1996 to provide funding for the clinical training of selected medical professions. The purpose of this funding is to compensate training sites for a portion of the costs of training provided in a clinical teaching environment. These costs have traditionally been covered by teaching facilities charging higher rates for patient care. However, in today's highly competitive market, third party payers are increasingly unwilling to pay the higher charges at teaching institutions.

The MERC Trust Fund was established in 1996 and funded in 1997, with $5 million from the General Fund and $3.5 million from the Health Care Access Fund. These dollars have been matched with approximately $9.3 million federal Medicaid funds, for a total of approximately $17.8 million to be distributed in 1998. These funds will be distributed to teaching programs on the basis of the number of eligible trainees and the average cost of clinical training (based on a statewide average for each of the provider types covered by MERC).

The legislature provided ongoing funding for MERC in the 1998 legislative session by appropriating $10 million from the general fund for distribution in fiscal year 1999 and increasing the Minnesota Department of Health's budget base by $5 million annually beginning in FY 2000. The legislature also authorized the Department of Human Services to seek a federal match on these dollars. The distribution formula for the general fund dollars and federal match is the same as for the 1998 MERC Trust Fund distribution.

In addition to the general fund appropriations, the 1997 legislature authorized removal of the medical education component of the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC) capitation rates, and a transfer of these funds to the MERC Trust Fund for distribution beginning in 1999. *These dollars from the public programs are not new dollars for medical education.* Rather, they are existing dollars that can be used more effectively and efficiently by distributing them through the MERC Trust Fund. The current estimate of the amount that will be transferred from PMAP/PGAMC to the MERC Trust Fund for 1999 is $22 million.

1998 MERC Trust Fund Distribution

Eligible applicants for the Trust Fund are Minnesota-based teaching institutions and programs that are accredited to train physicians, doctor of pharmacy practitioners, dentists, advanced practice nurses, and physician assistants. Applications are submitted by the sponsoring institutions, the organizations that are organizationally and/or financially responsible for one or more teaching programs. Funds are disbursed to the sponsoring institutions, with explicit requirements to pass the funds through to the training sites where clinical training takes place.

An important feature of the MERC Trust Fund is that it supports teaching activities wherever they occur. Medical education in Minnesota currently takes place in a very wide variety of settings, not just in urban hospitals. Information obtained from 1998 Trust Fund applications confirms that clinical medical education is conducted in urban and rural settings, and in small and large patient clinics; 56% of the training sites that will receive MERC funds are clinical training sites in the metropolitan area, 44% are clinical training sites in the rural area. Approximately 70% of the training sites are hospitals and 30% are non-hospital settings.

Applications for the 1998 Trust Fund were received from 16 sponsoring institutions that applied on behalf of 154 teaching programs, representing over 300 sites of training and 2,710 trainees. The largest share (87%) of the 1998 MERC Trust Fund will go to cover the cost of clinical training for medical residents. This is because medical residents make up over 65% of the trainees covered by the Trust Fund, and also because of the relatively high costs per trainee for medical residents are the highest at $146,765. Medical *students*, dental residents and dental *students* will each receive between 3% and 4% of the Trust Fund dollars, for a total of 11% of the Trust Fund. The remaining provider types (advanced practice nurses, physician assistants and doctor of pharmacy practitioners) will each receive approximately 1% or less of Trust Fund dollars, which reflects the fact that these provider types had relatively low training costs per trainee, small numbers of eligible trainees, or both low training costs and few trainees.

Recommendations

The 1997 legislature requested the Commissioner of Health provide recommendations on: 1) an allocation formula for distribution of the medical education funds from the Prepaid Medical Assistance and General Assistance Medical Care Programs, 2) additional broad based funding sources and 3) feasibility of including a carve out of current MinnesotaCare capitation rates allocated for medical education to the Trust Fund. The Commissioner's recommendations to the 1998 legislature, and the action taken by the legislature are summarized below.

Recommendations on Distribution of the Medical Education Funds from the Prepaid Medical Assistance and General Assistance Medical Care Programs:

These dollars should be distributed based on a simple additive formula that weighs equally the amount of medical education at each site plus the amount of public program volume at each site. Thus each factor, the education factor and the public program volume factor, would receive 50% weight in determining the distribution of funds.

In addition to the above formula, the Commissioner also recommended:

- "Public program volume" should be calculated based on a site's revenue from Medical Assistance, General Assistance Medical Care, Prepaid Medical Assistance and Prepaid General Assistance Medical Care.

- Training sites that have no public program revenue should be ineligible for a grant from this fund.

The Commissioner of Health submitted this recommendation to the legislature in a separate report titled "Recommendations on Distribution of PMAP/PGAMC Funds," in February 1998. A summary of the report is provided in Part III.

The legislature accepted the commissioner's recommendations and codified the distribution formula and two related considerations on public program revenue.

Recommendation on Additional Broad Based Funding Sources:

The MERC Advisory Committee has consistently recommended that MERC be funded from a broad-based, stable source of revenue, specifically general fund appropriations. This recommendation is consistent with the proposal the Commissioner submitted to the 1998 legislature for ongoing MERC funding from the general fund.

In addition to this funding, the MERC Advisory Committee has expressed a commitment to pursue the inclusion of MERC as a recipient of a portion of any proceeds arising from Minnesota's litigation with the tobacco companies. The Governor has already stated his interest in having MERC share in any settlement or judgement proceeds, both for medical education activities as well as for medical research.

The 1998 legislature indicated their continuing support of medical education in Minnesota by appropriating $10 million from the general fund for distribution in FY 1999 and increasing the Minnesota Department of Health's budget base by $5 million annually beginning in FY 2000. The legislature also authorized the Department of Human Services to seek a federal match on these dollars.

Recommendation on Medical Education Carve Out from MinnesotaCare:

The Commissioner of Health, in consultation with the Commissioner of Human Services recommended that there be no transfer of an education component from the MinnesotaCare rates to the Trust Fund at this time.

MinnesotaCare is a relatively new program and the enrollment has grown rapidly over the past few years. As the population enrolled in MinnesotaCare has changed, the average cost per patient has risen dramatically. Because of this change in the population, providers and health plans have expressed concerns about the adequacy of the MinnesotaCare rates, and believe that removing a portion for medical education would result in greater difficulties for MinnesotaCare providers. While MinnesotaCare rates are based on Medical Assistance, most of the MinnesotaCare population has not previously had a payment source that included a medical education component.

The 1998 legislature made no changes, and there will be no carve-out from the Minnesota-Care rates for distribution through the MERC Trust Fund.

Future Issues

Targeting Funds in Accordance with the Purpose of MERC

The 1998 legislature took action to assure that the MERC Trust Fund continues to serve its purpose in providing needed funding for medical education in Minnesota. The legislature enacted two provisions that allow the Commissioner of Health and the MERC Advisory Committee to review the provider groups that are eligible for MERC funding. *Senate File 3346, Article 2, Section 8.* First, the Commissioner and the MERC Advisory Committee were given authority to review provider groups added to the statute after January 1, 1998 to evaluate whether the group should be eligible for funding. In performing this review, the Commissioner and the MERC Advisory Committee are to consider the degree to which the training of the provider group:

(1) takes place in patient care settings which are consistent with the purpose of the MERC Trust fund;
(2) is funded with patient care revenues;
(3) takes place in patient care settings which face increased financial pressure as a result of competition with nonteaching patient care entities, and
(4) emphasizes primary care or specialties which are in undersupply in Minnesota.

Second, the legislature authorized the Commissioner and the MERC Advisory Committee to review provider groups that were added to the eligible list of provider groups prior to January 1, 1998, to assure that the Trust Fund money continues to be distributed consistent with the purpose of the statute. In both cases, the review of the provider group must be reported to the Commission on Health Care Access for final action. These provisions are important tools to assure that Trust Fund dollars continue to support medical education in patient care training sites that have experienced a loss of medical education funding due to increased competition in the health care market.

The legislature directed the Commissioner of Health to determine if there are other criteria for weighting future distributions of medical education and research funds beyond the current statutory criteria, including the criteria that trainees continue to practice in Minnesota. This provision allows the Commissioner to continue to consider how to best target resources consistent with the purposes of MERC in the changing health care environment. For example, in addition to the new criteria named above, the Commissioner and MERC Advisory Committee might consider the degree to which MERC funding could assist in addressing workforce priorities.

It is important that there are opportunities to review provider eligibility and distribution criteria in light of changes in the amount of funding available for the MERC Trust Fund. The appropriation of $10 million for FY 1999 and $5 million annually thereafter is significantly less than the $17.8 million to be distributed in 1998. The Department of Human Services has been directed to seek a federal match for these dollars, but we do not expect to maintain the federal match that contributed $9.3 million to the state appropriation of $8.5 million. We will also be

distributing funds from the carve-out from PMAP and PGAMC, however, these funds are not new money, but rather redistribution of existing dollars. Therefore, the MERC Trust Fund will be smaller and spread thinner among the current eligible provider groups. As new provider groups are added, the distribution and its impact will be more diffuse.

Appropriate Staffing and Support

In order to implement and maintain the MERC Trust Fund, appropriate staffing and financial support is required. The MERC Trust Fund, in 1998 will distribute $17.8 million. In 1999 the distribution amount will be approximately $30 million or higher, with two separate pools of funding and two different distribution formulas. In addition, the 1998 legislation requires the Department of Health to evaluate provider eligibility. The legislation also requires the Department of Health to conduct a study of the structure and composition of the MERC Advisory Committee, determine whether adjustments are necessary in the distribution formula for the PMAP/PGAMC medical education dollars, and determine whether additional criteria for weighting future distributions of the Trust Fund are necessary. This study might include an evaluation of workforce planning as a distribution criteria. Finally, the MERC project has also had as a part of its charge a focus on research, which has so far been largely neglected due to staff limitations. In order to execute the MERC Trust Fund responsibly, administrative dollars must be allocated.

I. INTRODUCTION

Purpose

This report was prepared pursuant to three statutory reporting requirements. Minnesota Statute section 62J.69 directs the Commissioner of Health to provide an annual summary report to the legislature on program implementation. The 1997 legislature also requested that the Commissioner consider funding sources for the Medical Education and Research Costs (MERC) Trust Fund, with advice from the MERC Advisory Committee. *1997 Minn. Laws Chapter 203, Article 2, Section 31.* Specifically, the law requires the Commissioner to: 1) consider additional broad-based funding sources, and recommend potential sources of funding to the legislature, and 2) report recommendations on the feasibility of including a carve out of current MinnesotaCare capitation rates allocated to medical education to the Trust Fund. These activities are to be in consultation with the MERC Advisory Committee and the Commissioner of Human Services and reported to the legislature. This report fulfills these reporting requirements. The 1997 MERC Statute and uncodified session laws are included as Appendix A. This report was completed after the 1998 legislature adjourned. Therefore this report includes the legislature's action on the Commissioner's recommendations. Appendix B contains the 1998 legislation related to MERC, as found in Senate File 3346 (to be entered in the 1998 Minnesota Session Laws at Chapter 407).

The 1997 legislation contains an additional statutory reporting requirement. Minnesota Statute section 62J.69 subdivision 3 directs the Commissioner to report to the legislature an allocation formula for distribution of the medical education dollars that are to be carved out of PMAP/PGAMC. This report, titled "Recommendations on Distribution of PMAP/PGAMC Funds," was submitted to the legislature in February 1998. A summary of the report is provided in Part III.

History of the MERC Trust Fund

The Medical Education and Research Costs Trust Fund was established in 1996 to provide funding for the clinical training of selected medical professions. The purpose of this funding is to compensate training sites for a portion of the costs of providing a clinical teaching environment within a patient care setting. These costs have traditionally been covered by teaching facilities charging higher rates for patient care, a strategy that is becoming more and more difficult as competition increases.

Medical education and research are vital activities affecting not only the health care community, but the health of every citizen and the economy of the entire state. Health care is one of the state's leading industries, employing at least 190,000 Minnesotans and generating at least $15 billion of the annual gross state product. The state's medical education and research infrastructure significantly influences Minnesota's health care system and overall economy.

Patient care at teaching institutions is more costly than similar care at non-teaching institutions. Teaching institutions have typically financed a portion of the cost of teaching and research activities through patient care revenues. However, in today's highly competitive market, third party payers are increasingly unwilling to pay the higher charges at teaching institutions.

In 1993 the Minnesota State Legislature directed the Commissioner of Health to examine medical education and research costs. The MERC Advisory Task Force was created in 1993 and has provided essential input to the Department of Health's study of medical education and research. The Department has issued annual reports documenting the issues faced by medical education programs and teaching hospitals in the competitive health care market.

The legislature created the MERC Trust Fund in 1996 and provided a one-year base appropriation in 1997, with $5 million from the General Fund and $3.5 million from the Health Care Access Fund. These dollars have been matched with approximately $9.3 million federal Medicaid funds, for a total of approximately $17.8 million. These funds will be distributed in 1998 to teaching programs on the basis of the number of eligible trainees and the average cost of clinical training (based on a statewide average for each of the provider types covered by MERC).

The legislature provided ongoing funding for MERC in the 1998 legislative session by appropriating $10 million from the general fund for distribution in FY 1999 and increasing the Minnesota Department of Health's budget base by $5 million annually beginning in FY 2000. The legislature also authorized the Department of Human Services to seek a federal match on these dollars. The distribution formula for the general fund dollars and federal match is the same as for the 1998 MERC Trust Fund distribution

In 1997, the legislature also authorized removal of the medical education component of the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC) capitation rates, and a transfer of these funds to the MERC Trust Fund for distribution beginning in 1999. *It is important to note that these dollars from PMAP are <u>not</u> new dollars going to medical education.* Rather they are dollars that can be used more effectively and efficiently by distributing them through the Trust Fund. The current estimate of the amount that will be transferred from PMAP/PGAMC to the MERC Trust Fund for 1999 is $22 million.

II. 1998 MERC Trust Fund Distribution

Eligibility Criteria for the 1998 MERC Trust Fund

Minnesota Statute section 62J.69 establishes the criteria for eligibility for the MERC Trust Fund in 1998. Accredited medical education programs are eligible for funding through the Trust Fund if they meet the following criteria:

1) the sponsoring institution, the program, and the site of training must all be in Minnesota, *Minn. Stat. §62J.69, subd. 2 (c) (Supp. 1997)*;

2) the training program must provide training to one of the designated provider types: physicians (medical students and residents), doctor of pharmacy practitioners, dentists, advanced practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), or physician assistants, *Minn. Stat. §62J.69 , subd. 1 (a) (Supp. 1997);* and

Provider Types Included in the MERC Trust Fund

- ❑ Advanced Practice Nurses;
- ❑ Dental Students;
- ❑ Dental Residents;
- ❑ Medical Students;
- ❑ Medical Residents;
- ❑ PharmD Students;
- ❑ PharmD Residents;
- ❑ Physician Assistants

3) the training program must provide clinical training, where *clinical* training is defined as "accredited training that is funded and was historically funded in part by inpatient care revenues, and that occurs in both inpatient and ambulatory care settings." *Minn. Stat. §62J.69 subd. 1(b) (Supp. 1997).*

The statute provides that MERC funding will be distributed based on a uniform percentage of the average clinical training costs per trainee:

> "The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total eligible trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program." *Minn. Stat. §62J.69 subd. (2) (d) (Supp. 1997).*

Funding Available for 1998

The MERC Trust Fund was funded in 1997, with an appropriation of $5 million from the General Fund and $3.5 million from the Health Care Access Fund. In addition, the Department of Human Services was directed to seek a federal match for the funds through the state Medicaid program.

$8,500,000 General/Access Fund
$9,260,133 Federal Match

$17,760,133 Total 1998 Trust Fund

The state has developed a state plan amendment to achieve a federal match. The plan amendment allows Minnesota to increase the Medicaid payments to specific teaching hospitals, and to have these hospitals assign this increase directly to the MERC Trust Fund for distribution according to the MERC formula and process. HCFA has approved this amendment. This match will add another $9,260,133, bringing the total Trust Fund for 1998 distribution to $17,760,133.

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Development of the 1998 MERC Trust Fund Grant Application Process

Immediately after the 1997 legislature appropriated funds to the MERC Trust Fund, staff began work on implementation of the Trust Fund, which consisted primarily of development of the application, development of a web site for information sharing, and conducting technical assistance meetings to assist persons completing the application.

The MERC Trust Fund application was developed through the collaborative work of Department of Health staff, and the MERC advisory committee and it's eligibility subcommittee. The eligibility subcommittee was open to all persons interested in participating, and included representatives of health plans, provider networks, teaching institutions for the eligible providers, and other interested stakeholders. A list of current MERC advisory committee members is included as Appendix C. A list of the MERC eligibility subcommittee members is included as Appendix D.

Content of the Application

The MERC Trust Fund application is the source of the information needed for distribution of the Trust Fund dollars, as well as a source of information on the costs and revenues of medical education. Specifically, the application is required by statute to include information on the costs of clinical training, revenues for clinical training, the number of trainees and the training sites they utilize, and other information necessary to determine eligibility for the Trust Fund. Throughout the application development process, the staff and advisory committee worked hard to assure that the application was as simple as it could be given the statutory requirements. All elements in the application are either specifically required by the MERC statute, or necessary for determining the eligibility or appropriate distribution of the Trust Fund.

Technical Assistance to Applicants

The MERC Trust Fund web site was established in the Fall of 1997, as a method of communicating with the diverse applicant groups and interested persons (e.g. sponsoring institutions, training programs, and teaching sites for all eligible provider types) through out the state of Minnesota. The web site was announced in the application materials and was effective in communicating critical and timely information during the application process. The website offered updated information regarding the Trust Fund and the application process, a list of all questions received on the MERC application with answers, an e-mail link to communicate with MERC staff, information on the MERC technical assistance meetings, and schedules of committee and subcommittee meetings. The MERC web site is *www.health.state.mn.us/divs/hpsc/hep/merc/merc.htm.* A copy of the MERC HomePage can be found in Appendix E.

Due to the large numbers of programs and training sites applying for the MERC Trust Fund, and the fact that these programs and sites were located throughout the state, Department of Health staff held a technical assistance meeting via videoconference on September 30, 1997, approximately three weeks after the applications were mailed. The meeting was attended by approximately 50 persons at videoconference sites in St. Cloud, Duluth, Rochester, and St. Paul.

Applications to the 1998 MERC Trust Fund

Applications for the 1998 MERC Trust Fund were due in November, 1997. The Trust Fund received 16 applications on behalf of 154 teaching programs, representing over 300 sites of training and 2,710 trainees. Applications are submitted by ***sponsoring institutions,*** the organizations that are organizationally and/or financially responsible for one or more ***teaching programs***. Funds will be disbursed to the sponsoring institutions, with explicit requirements to pass the funds through to the ***training sites*** (hospitals and clinics) where clinical training occurs. Many entities are both sponsoring institutions *and* training sites. Many hospitals and clinics are training sites for several different teaching programs.

The 1998 MERC Trust Fund is distributed based on a formula which reflects the number of eligible FTEs at a particular site as well as the statewide average cost of clinical training for that provider type. The Trust Fund reimburses a *uniform percentage of clinical training costs for each of the 8 provider types.* For the 1998 Trust Fund, this percentage is 5.9%. The annual average clinical training costs per trainee vary significantly across the 8 provider types (see table below).

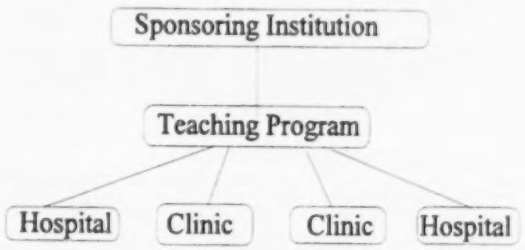
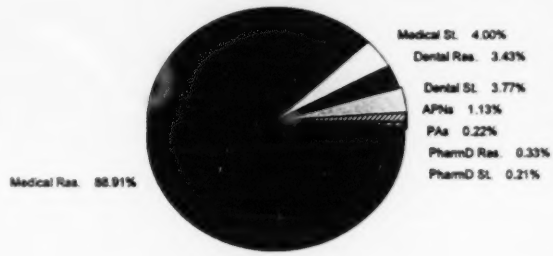


Table 1
MERC Distribution By Provider Type

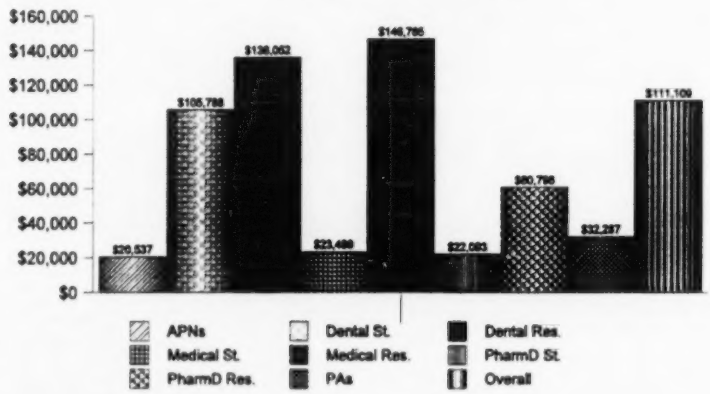
Provider Type	Teaching Programs	Eligible FTEs	Average Cost Per Trainee	Adjusted Total Costs	% of Trust Fund	Grant Amount	Grant per Trainee	% of Costs Covered
Adv. Prac. Nurses	11	165.1	$20,537	$3,390,043	1.1255%	$199,899	$1,211	5.90%
Dental Students	1	107.2	$105,788	$11,341,531	3.7656%	$668,771	$6,238	5.90%
Dental Residents	12	76.0	$136,052	$10,345,394	3.4348%	$610,032	$8,023	5.90%
Medical Students	5	513.3	$23,489	$12,056,977	4.0031%	$710,958	$1,385	5.90%
Medical Residents	117	1,783.6	$146,765	$261,771,874	86.9125%	$15,435,778	$8,654	5.90%
PharmD Student	1	28.9	$22,093	$638,488	0.2120%	$37,649	$1,303	5.90%
PharmD Resident	6	16.3	$60,796	$987,935	0.3280%	$58,255	$3,585	5.90%
Physician Assistant	1	20.4	$32,287	$657,848	0.2184%	$38,791	$1,904	5.90%
Total	154	2,710.8	$111,109	$301,190,089	100.0000%	$17,760,133	$6,552	5.90%

The largest share (86.9%) of the 1998 MERC Trust Fund will go to cover the cost of clinical training for medical residents. This is because medical residents make up over 65% of the trainees covered by the Trust Fund, and also because costs per trainee for medical residents are the highest at $146,765. Taken together, this means that 86.9% of the clinical training costs reported through the MERC application process were for the training of medical residents.

Distribution of Trust Fund by Provider Type

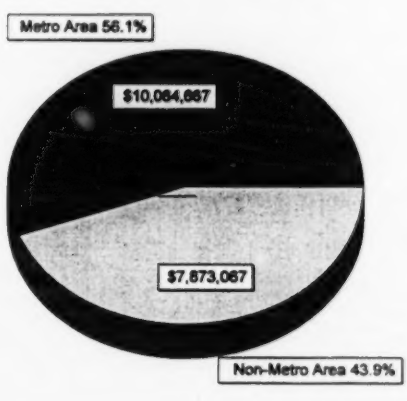


Average Cost of Clinical Training by Provider Type

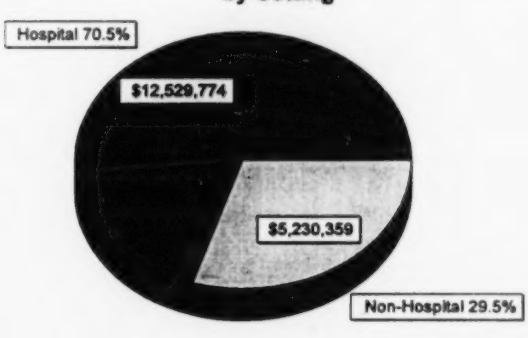


An important feature of the MERC Trust Fund is that it supports teaching activities wherever they occur. Medical education in Minnesota takes place in a very wide variety of settings, not just in urban hospitals. Today, clinical medical education takes place in urban and rural settings, and in small and

Distribution of Trust Fund Metro* v. Non-Metro



Distribution of Trust Fund by Setting



*Metro refers to the counties of Hennepin, Ramsey, Scott, Dakota, Anoka, Washington and Carver.

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large patient clinics as well as hospitals. This reflects the diversity of medical education, and the interest in preparing medical professionals for work in primary care settings and rural areas. The 1998 Trust Fund will be distributed to these diverse training sites across the state, with 56.1% of the Trust Fund going to metro sites and 43.9% going to non-metro sites. 70.5% of the Trust Fund will go to hospitals, while 29.5% will go to clinic sites.

Some training sites host hundreds of trainees in a variety of teaching programs throughout the year. Other training sites host only a small number of trainees, perhaps only for a few weeks out of the year. This also reflects the diversity of training experiences utilized by Minnesota's medical education system. Some teaching programs, such as primary care residencies and advanced practice nurse training programs, prefer to have their students rotate to many small sites for short rotations in order to expose them to more diverse practice settings. These sites are often very small, and are frequently non-metro clinics. Each of the training sites, regardless of the number of trainees they host, makes a significant commitment to medical education in Minnesota, and experience costs related to this commitment.

Disbursements from the 1998 MERC Trust Fund

The *sponsoring institutions* listed below have applied on behalf of the *teaching programs* they administer and the *training sites* used by these teaching programs. As required by the MERC statute, the sponsoring institutions report the following information for each teaching program: costs of clinical training, revenues associated with medical education, information on accreditation, and information on the training sites used by the teaching program, and the number of Full Time Equivalents (FTEs) trained at each training site. Funding from the MERC Trust Fund is directed to the Sponsoring Institutions, with specific requirements that these funds be forwarded to the actual training sites.

Table 2
Applications to the 1998 Trust Fund

Sponsoring Institution	City	Teaching Programs	Eligible FTEs
Abbott Northwestern Hospital	Minneapolis	2	32.0
Allina Health System/United Hospital	Minneapolis	1	17.0
Augsburg College	Minneapolis	1	20.4
College of St. Catherine	St. Paul	1	13.3
College of St. Scholastica	Duluth	2	15.3
Duluth Medical Education Council, Inc.	Duluth	1	29.0
Hennepin County Medical Center	Minneapolis	11	192.9
Mankato State University School of Nursing	Mankato	1	15.9
Mayo Foundation	Rochester	64	919.4
Minneapolis Sports Medicine Center	Minneapolis	1	1.6
Regions Hospital	St. Paul	6	62.9
St. Mary's Hospital U of MN	Minneapolis	1	38.0
United Hospital and Children's Healthcare	St. Paul	2	3.3
University of MN Academic Health Center	Minneapolis	57	1,323.5
Winona State University	Winona	2	18.4
Women's HealthCare Nurse Practitioner Program	St. Paul	1	8.0
TOTAL		154	2,710.8

Applications are coordinated by, and funding directed to, the sponsoring institutions, rather than the training sites, to preserve the integrity of the teaching programs, and so that accurate and complete information about medical education teaching programs can be obtained. Trust Fund dollars will flow from the Trust Fund through the sponsoring institutions to the training sites.

The table below reports the total MERC Trust Fund monies that will be received by the training sites used for medical education in Minnesota.

Table 3: Clinical Training Sites

Training Site	City	Number of Eligible Trainees	Percent of Trust Fund	Grant Amount
St. Mary's Hospital	Rochester	384.69	16.86%	$2,994,574
Mayo Clinic	Rochester	370.27	16.27%	$2,890,271
Hennepin County Medical Center	Minneapolis	375.89	13.87%	$2,463,066
Fairview University Medical Center	Minneapolis	308.33	11.42%	$2,027,792
Regions Hospital	St. Paul	207.43	7.61%	$1,350,994
Rochester Methodist Hospital	Rochester	156.78	7.00%	$1,243,215
U of MN Dental School Clinic	Minneapolis	156.03	5.97%	$1,060,430
Fairview Riverside Hospital	Minneapolis	83.88	3.75%	$665,495
Abbott Northwestern Hospital	Minneapolis	74.90	2.12%	$376,657
North Memorial Medical Center	Robbinsdale	39.08	1.47%	$261,705
Children's Health Care St. Paul	St. Paul	43.21	1.40%	$248,168
U of MN Surgery	Minneapolis	22.00	1.07%	$190,393
St. Joseph's	St. Paul	19.63	0.87%	$155,344
Children's Health Care Minneapolis	Minneapolis	28.33	0.77%	$137,424
HealthSystem MN	St. Louis Park	14.88	0.73%	$128,775
Mayo Psychiatry & Psychology Treatment Center	Rochester	14.90	0.64%	$114,410
St. Luke's Hospital of Duluth	Duluth	14.06	0.61%	$109,000
United Hospital	St. Paul	13.14	0.60%	$106,113
St. Mary's Medical Center	Duluth	12.25	0.53%	$93,425
St. Johns Hospital HealthEast	Maplewood	11.01	0.41%	$73,476
University Affiliated Family Physicians	St. Paul	8.42	0.41%	$72,869
HealthPartners	Bloomington	19.92	0.40%	$70,185
Duluth Family Practice Center	Duluth	16.95	0.38%	$66,728
Methodist Hospital	St. Louis Park	13.34	0.37%	$66,096
Gillette Children's Hospital	St. Paul	6.65	0.27%	$47,200
Duluth Clinic	Duluth	32.37	0.25%	$44,500
Rural Physician Program	Minneapolis	23.00	0.18%	$31,856
Park Nicollet Clinic	Minneapolis	9.02	0.15%	$25,810
St. Cloud Hospital	St. Cloud	3.29	0.14%	$25,518
Community-University HealthCare Center	Bloomington	4.79	0.14%	$24,732
Mankato Clinic	Mankato	4.49	0.12%	$21,812
U of MN Lab and Pathology	Minneapolis	2.46	0.12%	$21,289
Park Nicollet Hand Center	St. Louis Park	2.00	0.10%	$17,308
Institute for Research and Education	Minneapolis	2.00	0.10%	$17,308
Family Practice Center	St. Cloud	1.88	0.09%	$15,466
Unity Hospital	Fridley	2.59	0.08%	$14,971
Waseca Area Medical Center	Waseca	1.93	0.08%	$13,431
Duluth Ob/Gyn Assoc.	Duluth	9.19	0.07%	$12,734
Colon and Rectal Surgery Assoc	St. Paul	1.19	0.06%	$10,299
Other Clinics- combined		163.68	2.20%	$391,518
Other Hospitals- combined		30.92	0.33%	$57,774
TOTAL		**2,710.76**	**100.00%**	**$17,760,133**

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Issues Identified in the First Year of Trust Fund Implementation

Several issues were identified when staff and the MERC Advisory Committee developed the MERC application and the application process. Some of these issues could be resolved within the constraints of the MERC legislation, while others highlighted areas where legislative change should be considered. As a result of discussion of these issues, the Department put together a set of technical amendments to improve and simplify the administration of the MERC project. There are several issues that have not been resolved, and we anticipate additional issues to arise as we complete the first year's distribution and begin the process for distribution next year of the PMAP/PGAMC medical education funds. Below is a summary of some of the more significant issues we discussed to date. All of these issues, except the last two, were the subject of technical amendments in the 1998 legislative session. The discussion below includes the legislative action on these amendments.

Consolidate Reporting Requirements

Minnesota Statute section 62J.69 subdivision 2 (e) requires programs that receive a MERC Trust Fund grant submit an annual report, called the grant verification report, which would include information on the average cost per trainee, detailed breakdown of the components of these costs, and revenues and appropriations received for education purposes. This data is duplicative of the data required in the MERC application. This data was initially required because there was an expectation at the time the original MERC statute was written that the application data would be ***projections*** of FTEs, revenues, and costs for the upcoming year. The annual report would be filed after the grant was received, and would contain ***actual*** data. Presumably, there would be some reconciliation between these projected and actual figures. In developing the MERC Trust Fund process, it was decided that this would build in unnecessary complexity to the process. For actual, audited data to be submitted on the annual report, for example, we would need to wait 6-12 months after the conclusion of the fiscal year, which in some cases could be almost 2 years after receipt of the grant. In addition, reconciliation between projected data and actual would be time consuming and cumbersome. Instead, it was decided that the application for MERC funds would be based on the most recently completed fiscal year (for 1998 Trust Fund, this period was determined to be Fiscal Year 1996). This means that actual rather than projected data is received through the application process, and no reconciliation is required. Further, it means that the follow up annual report requirements can be greatly reduced. To avoid the problem of new programs, for whom no data on fiscal 1996 exists, the application allows a specific exemption for new programs, which can report fiscal 1997 data even if some of the data is not yet audited.

The 1998 legislature adopted the Department's proposed legislative language that eliminates these redundant items required in the annual report that are duplicative of information collected in the application process. The grant verification report will now contain only minimal information to assure that the money was forwarded to the appropriate training sites as required.

Refine Definition of "Clinical Training"

The definition of "clinical training," in the 1997 MERC statute is:

> " 'clinical training' means accredited training that is funded and was historically funded in part by inpatient care revenues and that occurs in both inpatient and ambulatory settings." *Minn. Stat. §62J.69 subd. 1 (b) (Supp. 1997).*

This language was intended to focus MERC funding on those teaching sites most at risk from increasing competition and to avoid "opening up" the MERC Trust Fund to many different kinds of practitioners, for whom the funding problems were not apparent. The difficulty came in attempting to operationalize this definition. There were many instances of teaching programs which were *exclusively* ambulatory-based that faced problems finding clinical training sites given the costs of clinical training and the increased competition with non-teaching sites. In some cases, entire provider types, which had been specifically included in the MERC Trust Fund would have some difficulty demonstrating historical funding from inpatient care revenues. In other cases, programs were too new to have any "historical" data to show this. Many programs argued that they had inpatient revenues supporting the program, but in very indirect ways. In all, the discussion centered on the fact that MERC was created to address problems of funding for programs whose training was centered in "patient care" settings, both inpatient and ambulatory, and that MERC should not set up policies that would discourage ambulatory-based training. To accomplish this, the Department proposed changes to the definition of clinical training to remove the focus on "historical" funding, and to replace "inpatient" with "patient" care revenues. The legislature approved these changes.

Other Unfunded Costs

Minnesota Statute section 62J.69 subdivision 2 (c) (7) currently requires MERC Trust Fund applicants provide "a statement identifying unfunded costs" on the MERC application. MDH staff and the MERC advisory committee had difficulty arriving at a precise, operational definition of "unfunded" costs. In one way or another, all costs are funded, whether through explicit means or through more informal cost shifting mechanisms. The purpose behind the original requirement for reporting of unfunded costs was to determine the costs that have been covered by funding sources "at risk" as competition increases. The committee decided that the cost and revenue information reported on the application could be utilized to estimate these costs. Specifically, unfunded costs are determined by taking total estimated clinical training costs and subtracting the amount of formal medical education funding derived from state and federal sources (e.g., Medicare, Medical Assistance, training grants) and other sources (e.g., tuition, private training grants). The difference between costs and formal revenues yields the amount of costs that are "at risk," because they are not covered by formal medical education funding, but are instead absorbed by the sites of training through cost shifting and other means.

The Department proposed and the legislature adopted language that eliminates the required statement of unfunded costs. Instead, the Department will continue to rely on the statutorily required cost and revenue reporting to determine costs "at risk."

New Enforcement Authority

In the existing MERC statute, sponsoring institutions are required to distribute Trust Fund dollars to the training sites but there is no language concerning the consequences should this not happen. The legislature enacted language that gives the Commissioner authority to act if a sponsoring institution did not distribute funds as required. The language requires the sponsoring institution to return funds that were not distributed within thirty days of a notice from the Commissioner of Health.

Clarify Definition of "Resident"

The MERC statute states that " 'medical education' means the accredited clinical training of physicians (medical students and residents) ..." *Minn. Stat. §62J.69, subd. 1 (a) (Supp. 1997)*. An issue was raised about the inclusion or exclusion of "fellows," those trainees who have typically completed a first residency program and who are completing advanced training in a sub-specialty. Department staff expressed concern about fellows being included in the Trust Fund pool because they are capable of providing significant unsupervised patient care, and because of a concern that fellows were possibly not intended to be included in the Trust Fund. The MERC Advisory Committee was asked to consider excluding fellows from Trust Fund eligibility.

The discussion of this issue at the MERC advisory committee meetings revealed that there is considerable difficulty in defining resident and fellow in a clear way, as the terms are used differently by different groups. For example, the Accreditation Council for Graduate Medical Education (ACGME) defines "resident" or "resident physician" as "any individual at any level in an ACGME-accredited GME program, including sub-specialty programs." *AMA/ACGME Graduate Medical Education Directory; 1997-1998, page 1243*. This definition does not distinguish between trainees in an initial residency program (often called residents) with those trainees (sometimes called fellows) that have completed a residency and are training for a sub-speciality. Some institutions refer to all of their medical trainees as fellows. It was then suggested that all post-graduate trainees up through their first 5 years of post-graduate training be eligible for Trust Fund grants. Under this criteria, fellows would qualify in the early years of sub-speciality training when supervision is greatest. Objections to this concept were that sub-specialist training is expensive, and that often those in the final year or two of sub-specialist training require a great deal of supervision, because they are doing very complex tasks.

The MERC Advisory Committee recommended that the ACGME definition of resident be used for MERC eligibility, because the use of the term "fellow" and "resident" vary from institution, and it was not clear what the legislature intended. Furthermore, the committee felt that MERC should recognize residents training in a sub-specialty as an important part of medical education in the state. Based on the committee's recommendation, the ACGME definition of resident was used in the application, and currently, fellows are eligible for MERC funding.

Discussion of Sites with Small FTEs

In 1998, the Trust Fund will be distributed, via the sponsoring institutions, to more than 300 different training sites around the state. The amounts to be received by these sites depends on the number of trainees at the site as well as the average cost of clinical training for that trainee type. Some training sites host hundreds of trainees from dozens of different training programs, and will receive funds well over $1 million. At the other end of the spectrum are training sites that host just a small number of trainees, perhaps only for part of the year. These training sites naturally will receive a very small amount from the Trust Fund. In all, almost 80% of the Trust Fund will go to the 7 training sites with grants in excess of $1 million, while just 0.4% of the Trust Fund will go to the 171 training sites with total grants of less than $1,000.

In reviewing the 1998 MERC application data, it became apparent to staff and advisory committee members that a relatively large number of training sites host a small number of FTEs. Concern was raised that there would be administrative costs associated with sponsoring institutions being required to

forward funds to these sites, and that perhaps the MERC process could be simplified by imposing some minimum threshold below which training sites would receive no funding, or to whom teaching programs would not be required to forward funds. The MERC Advisory Committee had several discussions regarding this issue. First, it was generally agreed that reporting for these sites was still important, in order to get a complete picture of the training programs. Second, it was agreed that the FTEs that rotate to sites with a small total number of trainees should still be accounted for in the distribution to the sponsoring institutions and the teaching programs. Discussion then centered around allowing the teaching program the option of whether or not to forward funds to training sites below some minimum threshold.

At one MERC Advisory Committee meeting, the Committee voted to recommend that funds associated with training sites that host less than 1 FTE for that program *could be* retained by the teaching program, and would not be required to be passed through to the site of training. The vote for this recommendation was four to four, with the chair breaking the tie voting in favor of the recommendation. Following this meeting, the Department received a number of letters and calls from organizations stating that they opposed the recommendation, or that as a sponsoring institution, they would forward these funds anyway. In fact, those sponsoring institutions that were thought to be helped by this recommendation were among those speaking most clearly against it.

There were several reasons for the objections. First it became clear that there were no administrative savings associated with this recommendation, because it would require that sponsoring institutions treat some sites differently than other sites. Also, some sites could be affected that have many FTEs in several different programs, because they host less than one FTE for a particular program. Although this could be addressed, the solution would be a significant *increase* in administrative costs. Another issue that was raised was that there are some provider types which would be more significantly affected than others. For example, 65% of the Physician Assistant training sites and 22% of the Advanced Practice Nursing training sites hosted less than 1 FTE (as compared to just 0.6% of the training sites for medical residents). Without the guarantee of funds, these sites may not be willing to provide the necessary data needed for the MERC application, and may also lose interest in hosting trainees.

Training at many sites for shorter durations is seen as desirable by many teaching programs, most particularly training for primary care providers. This is consistent with a desire to train professionals in a variety of settings, including small clinics in rural areas which may not have the resources or scope of activity to host many trainees. Small clinics that host a small number of trainees are still making a contribution to medical education, which should be recognized. A small amount of MERC funding may be even more critical for them than larger amounts are for bigger clinics. At the following MERC meeting, this issue was raised again. The MERC Committee voted to establish as a policy the recommendation that all MERC funds be required to be passed through, with no minimum limit.

III. Recommendations on Distribution of the Medical Education Funds from the PMAP and the PGAMC Programs

Upon the recommendation of the Commissioner of Health and the Commissioner of Human Services, the 1997 legislature directed that the medical education funding included in the capitated rates of the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC), be transferred to the MERC Trust Fund for distribution beginning in 1999. *Minn. Stat. § 256B.69 subd. 5c (Supp. 1997).*

The medical education funding that has been included in the capitation rates is an estimation of the historical medical education payments made to hospitals under the Medicaid fee-for-service system. In the fee-for-service system, DHS adds an amount to each hospital's payment to recognize Medicare's share of the hospital's medical education costs. The health plan capitation payments under PMAP are based on the total historical fee-for-service expenditures in a region. In most counties, the capitation paid to each health plan was the same regardless of the level of admissions they had at hospitals with high medical education costs. Thus, medical education funding was not tied to the amount of services provided in facilities with high education costs. DHS has the ability to remove from the capitation the amounts previously expended for medical education. Rather than invent a separate distribution system for these funds, DHS recommended directing these funds to the Medical Education and Research Trust Fund. The MERC Trust Fund represents an equitable vehicle for distribution of these funds to medical education providers. It is anticipated that directing this PMAP/PGAMC fund to the Trust Fund will result in fewer administrative costs as well as the potential for better targeting of scarce funds. ***It is important to note, however, that these dollars from PMAP are not new dollars going to medical education.*** Rather, they are dollars that can be used more effectively and efficiently by distributing them through the Trust Fund.

The current estimate of the amount from PMAP and PGAMC that will be transferred to the Trust Fund for distribution in January 1999 is $22 million. The amount will vary each year as the number of PMAP/PGAMC clients increases (due to the anticipated expansion of prepaid programs to the entire state).

Proposed Distribution Formula

The 1997 legislature authorized transferring the PMAP and PGAMC dollars to the MERC Trust Fund in 1999 and directed the Commissioner of Health to develop a distribution formula which "recognizes those teaching programs which serve higher numbers or high proportions of public program recipients" and "report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system." *Minn. Stat. §62J.69 subd. 3 (Supp. 1997).* A report titled "Medical Education and Research Costs (MERC) Recommendation on Distribution of PMAP/PGAMC Funds: A Report to the Legislature (February 1998)," has been submitted to the legislature. Copies are available on request from the Health Economics Program of the Minnesota Department of Health.

The report recommends a distribution formula for the PMAP/PGAMC medical education fund that is a simple additive formula which reflects equally the volume of medical education as well as the volume of public program service:

(Education Factor X 50%) + (Public Program Volume Factor X 50%) = Trust Fund Percentage

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Education Factor: # of eligible trainees multiplied by the average clinical training costs for that provider type divided by the grand total of clinical training costs across all sites. This is the standard MERC formula.

Public Program Volume Factor: The sites total public program revenues divided by the grand total of all sites' public program revenue.

Issues Involved in the Distribution of the Funds

The following issues were identified in the process of developing a distribution formula. The issues, policy considerations, and resolution are summarized below.

How much emphasis should be on education and how much on public program volume?

One of the primary difficulties the MERC Advisory Committee and subcommittee faced was reconciling the conflicting perspectives of participating entities. Although most participants recognized that the charge was to develop a distribution formula that reflected both teaching and public program volume, there was considerable difference of opinion as to how much each should contribute to the distribution formula. For some, this money was always intended for medical education, and had been paid out unfairly for years to entities that did not provide medical education services. For those that favored this view, the formula should emphasize education, with a small factor recognizing public program volume. For others, this money has been in the public program rates, and regardless of what it was intended for, it is now used for providers of public program services. For those favoring this viewpoint, the formula should reflect primarily the public program volume, with only a small portion of the formula driven by the amount of education performed. In the end, the recommended formula represents a 50/50 balance between education and public program volume.

How should public program volume be measured?

Should the measure of public program volume used in the formula focus on the ***Prepaid*** Medical Assistance Program (PMAP) and ***Prepaid*** General Assistance Medical Care (PGAMC) only, or should a broader definition of public program volume be used which would include fee for service revenues? The subcommittee discussed the fact that the funds were coming from the PMAP/PGAMC rates, and that perhaps it was logical to only consider PMAP/PGAMC volume in the formula. On the other hand, the

MERC application requires audited data from a fiscal year 2 years prior to the distribution year (for example, FY 96 is being used this year for distribution at the beginning of 1998). Because PMAP/PGAMC is expanding, using only PMAP/PGAMC revenues would be unfair for areas just starting prepaid programs. Final recommendation was that the measure of public program service should include both prepaid and fee for service revenue.

Training Sites with No Public Program Revenue

A concern was raised within the MERC Advisory Committee discussions that organizations that do not provide service to public program clients at all could qualify for a grant under the distribution formula. Because the funds are coming from public program rates, some felt that this would be inappropriate. Others felt that it would be inappropriate to eliminate such training sites, because the real value of medical education to the public programs occurs after training is done and the practitioners are out in the field providing health care services. Through discussions with the MERC Advisory Committee, it was concluded that as long as the measure of public program revenues included revenues for fee-for-service MA and GAMC as well as the prepaid programs, few sites would be eliminated with this requirement. Training sites that have no (0) public program revenues would be ineligible for funding from this source.

Legislative Response

The 1998 legislature accepted the Commissioner of Health's recommendation and enacted legislation containing the distribution formula described above. *Senate File 3346, Article 2, section 7*. The law defines public program volume as "revenue received from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care." This definition is consistent with the Commissioner's recommendation that the measure of public program volume should include both prepaid and fee for service revenues. The law also incorporates the Commissioner's recommendation that training sites that receive no public program revenue are ineligible for these medical education dollars.

IV. MERC Funding Sources

Recommendation on Additional Broad-Based Funding Sources

The Commissioner, with the advice of the MERC Advisory Committee, is required to evaluate future funding sources for MERC, and report them to the legislature. The MERC Advisory Committee has consistently recommended that MERC be funded from a broad-based, stable source of revenue, specifically general fund appropriations. This recommendation is consistent with the proposal the Commissioner submitted to the 1998 legislature for ongoing MERC funding from the general fund.

The 1998 legislature indicated their continuing support of medical education in Minnesota by appropriating $10 million from the general fund for distribution in FY 1999 and increasing the Minnesota Department of Health's budget base by $5 million annually beginning FY 2000. The legislature also authorized the Department of Human Services to seek a federal match on these dollars.

In addition to the above recommendation, this report covers two other funding-related issues. First, the Commissioner is required to make a recommendation on the possible inclusion of the education component of the MinnesotaCare rates in the Trust Fund. This issue is discussed below. Second, the report discusses an additional possible source of funding for MERC from proceeds from the tobacco litigation.

Recommendation on Medical Education Funding from MinnesotaCare

The Commissioner, in consultation with the Commissioner of Human Services, was required to study the appropriateness of transferring an educational component from the MinnesotaCare rates to the MERC Trust Fund. *1997 Minnesota Laws Chapter 203 Article 2, Section 31.* In carrying out this task, MDH requested that DHS staff attend several meetings of the MERC Advisory Committee to discuss the issues related to a possible transfer of funds from the MinnesotaCare program to the Trust Fund.

Based on these discussions, the Commissioner recommended to the 1998 legislature that there be no transfer of an education component from the MinnesotaCare rates to the Trust Fund at this time. MinnesotaCare is a relatively new program and the enrollment has grown rapidly over the last few years. As the population enrolled in MinnesotaCare has changed, the average cost per patient has risen dramatically. Because of this change in the population, providers and health plans have expressed concerns about the adequacy of the MinnesotaCare rates, and believe that removing a portion for medical education would result in greater difficulties for MinnesotaCare providers. While MinnesotaCare rates are based on Medical Assistance, most of the MinnesotaCare population has not previously had a payment source that included a medical education component. The Department of Human Services concurs with this recommendation.

The MERC Advisory Committee believes in general that all payers should be contributing to the costs of

medical education, but is in agreement that there are too many other issues related to the MinnesotaCare rates to warrant removing the education component for transfer to the Trust Fund. Should the environment related to the MinnesotaCare rates change in the future, this issue can be reexamined.

The 1998 legislature made no changes, and there will be no carve-out from the MinnesotaCare rates for distribution through the MERC Trust Fund.

Tobacco Litigation Proceeds

The MERC Advisory Committee has expressed a commitment to pursue the inclusion of MERC as a recipient of a portion of any proceeds arising from Minnesota's litigation with the tobacco companies. The Governor has already stated his interest in having MERC share in any settlement or judgement proceeds, both for medical education activities as well as for medical research.

V. Future Issues

Targeting Funds in Accordance with the Purpose of MERC

The 1998 legislature took action to assure that the MERC Trust Fund continues to serve its purpose in providing needed funding for medical education in Minnesota. The legislature enacted two provisions that allow the Commissioner of Health and the MERC Advisory Committee to review the provider groups that are eligible for MERC funding. *Senate File 3346, Article 2, Section 8.* First, the Commissioner and the MERC Advisory Committee were given authority to review provider groups added to the statute after January 1, 1998 to evaluate whether the group should be eligible for funding. In performing this review, the Commissioner and the MERC Advisory Committee are to consider the degree to which the training of the provider group:

(1) takes place in patient care settings which are consistent with the purpose of the MERC Trust fund;
(2) is funded with patient care revenues;
(3) takes place in patient care settings, which face increased financial pressure as a result of competition with nonteaching patient care entities, and
(4) emphasizes primary care of specialties, which are in undersupply in Minnesota.

Second, the legislature authorized the Commissioner and the MERC Advisory Committee to review provider groups that were added to the eligible list of provider groups prior to January 1, 1998, to assure that the Trust Fund money continues to be distributed consistent with the purpose of the statute. In both cases, the review of the provider group must be reported to the Commission on Health Care Access for final action. These provisions are important tools to assure that Trust Fund dollars continue to support medical education in patient care training sites that have experienced a loss of medical education funding due to increased competition in the health care market.

The legislature directed the Commissioner of Health to determine if there are other criteria for weighting future distributions of medical education and research funds beyond the current statutory criteria, including the criteria that trainees continue to practice in Minnesota. This provision allows the Commissioner to continue to consider how to best effectuate the purposes of MERC in the changing health care environment. For example, in addition to the new criteria named above, the Commissioner and MERC Advisory Committee might consider the degree to which MERC funding could assist in alleviating workforce shortages.

It is important that there are opportunities to review provider eligibility and distribution criteria in light of changes in the amount of funding available for the MERC Trust Fund. The appropriation of $10 million for 1999 and $5 million annually thereafter is significantly less than the $17.8 million to be distributed in 1998. The Department of Human Services has been directed to seek a federal match for these dollars, but we do not expect to maintain the federal match that contributed $9.3 million to the state

appropriation of $8.5 million. We will also be distributing funds from the carve-out from PMAP and PGAMC, however, these funds are not new money, but rather redistribution of existing dollars. Therefore, the MERC Trust Fund will be smaller and spread thinner among the current eligible provider groups. As new provider groups are added, the distribution will be more diffuse.

Appropriate Staffing and Support

In order to implement and maintain the MERC Trust Fund, appropriate staffing and financial support is required. The MERC Trust Fund, in 1998 will distribute $17.8 million. In 1999 the distribution amount will be approximately $30 million or higher, with two separate pools of funding and two different distribution formulas. In addition, the 1998 legislation requires the Department of Health to evaluate provider eligibility. The legislation also requires the Department of Health to conduct a study of the structure and composition of the MERC Advisory Committee, determine whether adjustments are necessary in the distribution formula for the PMAP/PGAMC medical education dollars, and determine whether additional criteria for weighting future distributions of the Trust Fund are necessary. This study might include an evaluation of workforce planning as a distribution criteria. Finally, the MERC project has also had as a part of its charge a focus on research, which has so far been largely neglected due to staff limitations. In order to execute the MERC Trust Fund responsibly, administrative dollars must be allocated. Without such funds, the money put into the Trust Fund may not be allocated properly, and necessary planning, policy development, and follow-up can not take place.

APPENDIX A

1997 MERC Statute and Uncodified Session Laws

MINNESOTA STATUTE 62J.69 MEDICAL EDUCATION AND RESEARCH TRUST FUND.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Medical education" means the accredited clinical training program of physicians (medical students and residents), doctor of pharmacy practitioners, dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(b) "Clinical training" means accredited training that is funded and was historically funded in part by inpatient care revenues and that occurs in both inpatient and ambulatory care settings.

(c) "Trainee" means students involved in an accredited clinical training program for medical education as defined in paragraph (a).

(d) "Health care research" means approved clinical, outcomes, and health services investigations that are funded by patient out-of-pocket expenses or a third-party payer.

(e) "Commissioner" means the commissioner of health.

(f) "Teaching institutions" means any hospital, medical center, clinic, or other organization that currently sponsors or conducts accredited medical education programs or clinical research in Minnesota.

Subd. 2. **Allocation and funding for medical education and research.** (a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall: (1) consider the interest of all stakeholders when selecting committee members; (2) select members that represent both urban and rural interests; and (3) select members that include ambulatory care as well as inpatient perspectives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers and other relevant stakeholders, including consumers. The advisory committee is governed by section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.

(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs operating in Minnesota. Applications must be submitted by the sponsoring institution on behalf of the teaching program, and must be received by September 30 of each year for distribution in January of the following year. An application for funds must include the following:

(1) the official name and address of the sponsoring institution and the official name and address of the facility or program on whose behalf the institution is applying for funding;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) the total number, type, and specialty orientation of eligible Minnesota-based trainees in each accredited medical education program for which funds are being sought;

(4) audited clinical training costs per trainee for each medical education program;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support;

(6) other revenue received for the purposes of clinical training;

(7) a statement identifying unfunded costs; and

(8) other supporting information the commissioner, with advice form the advisory committee, determines is necessary for the equitable distribution of funds.

(d) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total eligible trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources. Funds shall be distributed to the sponsoring institutions indicating the amount to be paid to each of the sponsor's medical education programs based on the criteria in this paragraph. Sponsoring institutions which receive funds from the trust fund must distribute approved funds to the medical education program according to the commissioner's approval letter. Further, programs must distribute funds among the sites of training based on the percentage of total program training performed at each site.

(e) Medical education programs receiving funds from the trust fund must submit annual cost and program reports through the sponsoring institution based on criteria established by the commissioner. The reports must include:

(1) the total number of eligible trainees in the program;

(2) the programs and residencies funded, the amounts of trust fund payments to each program, and within each program, the percentage distributed to each training site;

(3) the average cost per trainee and a detailed breakdown of the components of those costs;

(4) other state or federal appropriations received for the purposes of clinical training;

(5) other revenue received for the purposes of clinical training; and

(6) other information the commissioner, with the advice form the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training.

The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

(f) The commissioner is authorized to distribute funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the department of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the trust fund.

(g) The advisory committee shall continue to study and make recommendations on:

(1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and

(2) the costs and benefits associated with medical education and research.

Subd. 3. **Medical assistance and general assistance service.** The commissioner of health, in consultation with the medical education and research costs advisory committee, shall develop a system to recognize those teaching programs which serve higher numbers or high proportions of public program recipients and shall report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system.

1997 Minnesota Laws Chapter 225, Article 7, Section 2

Subdivision 1. **Medical Education.** Of the fiscal year 1998 health care access fund appropriation, $3,500,000 is for medical education research costs. This appropriation, plus the federal financial participation amount shall be distributed to medical assistance providers according to the distribution methodology of the medical education research trust fund established under Minnesota Statutes, section 62J.69. Any unspent funds in this appropriation do not cancel but may carry forward and be available in fiscal year 1999.

1997 Minnesota Laws Chapter 203, Article 1, Section 2, Subd. 5

Subd. 5. **Distribution to Medical Assistance Providers.** (a) Of the amount appropriated to the medical assistance account in fiscal year 1998, $5,000,000 plus the federal financial participation amount shall be distributed to medical assistance providers according to the distribution methodology of the medical education research trust fund established under Minnesota Statute 62J.69.

(b) In fiscal year 1999, the prepaid medical assistance and prepaid general assistance medical care capitation rate reduction amounts under Minnesota Statutes, section 256B.69, subdivision 5c, and the federal financial participation amount associated with the medical assistance reduction, shall be distributed to medical assistance providers according to the distribution methodology of the trust fund.

Minnesota Statute 256B.69 Prepayment Demonstration Project

Subd. 5c. **Medical education and research trust fund.** (a) Beginning in January 1999 and each year thereafter:

(1) the commissioner of human services shall transfer an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments resulting from clause (2), excluding nursing facility and elderly waiver payments, to the medical education and research trust fund established under section 62J.69;

(2) the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments shall be reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties; and

(3) the amount calculated under clause (1) shall not be adjusted for subsequent changes to the capitation payments for periods already paid.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research trust fund.

1997 Minnesota Laws Chapter 203, Article 2, Section 31

Sec. 31. **Funding sources for the medical education and research trust fund.** (a) The commissioner of health, in consultation with the medical education research costs advisory committee, shall continue to consider additional broad-based funding sources, and shall recommend potential sources of funding to the legislature by February 15, 1998.

(b) The commissioner of health, in consultation with the commissioner of human services, shall examine the appropriateness of transferring an educational component from the MinnesotaCare rates to the medical education and research trust fund, and the appropriate amount and timing of any such transfer. The commissioner shall report recommendations on the feasibility of including MinnesotaCare funding in the trust fund to the legislature by February 15, 1998.

APPENDIX B

1998 Minnesota Health and Human Services Omnibus Bill, Senate File 3346, MERC Provisions

KEY: ~~stricken~~ = old language to be removed
underscored = new language to be added

[MEDICAL EDUCATION AND RESEARCH TRUST FUND.] Of the general fund appropriation, $10,000,000 in fiscal year 1999 is to the commissioner for the medical education and research trust fund. Of this amount, $5,000,000 shall become part of base level funding for the biennium beginning July 1, 1999.
[MERC FEDERAL FINANCIAL PARTICIPATION.]
(1) The commissioner of human services shall seek to maximize federal financial participation for payments for medical education and research costs.
(2) If the commissioner of human services determines that federal financial participation is available for the fiscal year 1999 appropriation for the medical education and research trust fund under this subdivision, the commissioner of health shall transfer to the commissioner of human services the amount of state funds necessary to maximize the federal funds.
(3) The transferred amount, plus the federal financial participation amount, shall be distributed to medical assistance providers according to the distribution methodology of the medical education research trust fund established under Minnesota Statutes, section 62J.69.

Sec. 5. Minnesota Statutes 1997 Supplement, section 62J.69, subdivision 1, is amended to read:
Subdivision 1. [DEFINITIONS.] For purposes of this section, the following definitions apply:
(a) "Medical education" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and

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certified nurse midwives), and physician assistants.

(b) "Clinical training" means accredited training for the health care practitioners listed in paragraph (a) that is funded ~~and was historically funded~~ in part by ~~inpatient~~ patient care revenues and that occurs in ~~both~~ either an inpatient ~~and~~ or ambulatory patient care ~~settings~~ training site.

(c) "Trainee" means students involved in an accredited clinical training program for medical education as defined in paragraph (a).

(d) "Eligible trainee" means a student involved in an accredited training program for medical education as defined in paragraph (a), which meets the definition of clinical training in paragraph (b), who is in a training site that is located in Minnesota and which has a medical assistance provider number.

(e) "Health care research" means approved clinical, outcomes, and health services investigations that are funded by patient out-of-pocket expenses or a third-party payer.

~~(e)~~ (f) "Commissioner" means the commissioner of health.

~~(f)~~ (g) "Teaching institutions" means any hospital, medical center, clinic, or other organization that currently sponsors or conducts accredited medical education programs or clinical research in Minnesota.

(h) "Accredited training" means training provided by a program that is accredited through an organization recognized by the department of education or the health care financing administration as the official accrediting body for that program.

(i) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for an accredited medical education program in Minnesota and which is accountable to the accrediting body.

Sec. 6. Minnesota Statutes 1997 Supplement, section 62J.69, subdivision 2, is amended to read:

Subd. 2. [ALLOCATION AND FUNDING FOR MEDICAL EDUCATION AND RESEARCH.] (a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall: (1) consider the interest of all stakeholders when selecting committee members; (2) select members that represent both urban and rural interest; and (3) select members that include ambulatory care as well as inpatient persp tives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross and Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers, and other relevant stakeholders, including consumers. The advisory committee is governed by section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.

(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs operating in Minnesota. Applications must be submitted by the sponsoring institution on behalf of the teaching program, and must be received by September 30 of each year for distribution in January of the following year. An application for funds must include the following:

(1) the official name and address of the sponsoring institution and the official name and address of the facility or ~~program~~ programs on whose behalf the institution is applying for funding;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) ~~the total number, type, and specialty orientation of eligible Minnesota based trainees in~~ for each accredited medical education program for which funds are being sought the type and specialty orientation of trainees in the program, the name, address, and medical assistance provider number of each training site used in the program, the total number of trainees at each site, and the total number of eligible trainees at each training site;

(4) audited clinical training costs per trainee for each medical education program where available or estimates of clinical training costs based on audited financial data;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments;

(6) other revenue received for the purposes of clinical training; and

(7) ~~a statement identifying unfunded costs; and~~

~~(8)~~ other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds.

(d) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total eligible trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources. Funds shall be distributed to the sponsoring institutions indicating the amount to be paid to each of the sponsor's medical education programs based on the criteria in this paragraph. Sponsoring institutions which receive funds from the trust fund must distribute approved funds to the medical education program according to the commissioner's approval letter. Further, programs must distribute funds among the sites of training ~~based on the percentage of total program training performed at each site.~~ as specified in the commissioner's approval letter. Any funds not distributed as directed by the commissioner's approval letter shall be returned to the medical education and research trust fund within 30 days of a notice from the commissioner. The commissioner shall distribute returned funds to the appropriate entities in

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accordance with the commissioner's approval letter.

(e) Medical education programs receiving funds from the trust fund must submit ~~annual cost and program reports~~ a medical education and research grant verification report (GVR) through the sponsoring institution based on criteria established by the commissioner. If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of the medical education and research trust fund grant to the medical education and research trust fund within 30 days of a notice from the commissioner. The commissioner shall distribute returned funds to the appropriate entities in accordance with the commissioner's approval letter. The reports must include:

(1) the total number of eligible trainees in the program;

(2) the programs and residencies funded, the amounts of trust fund payments to each program, and within each program, the ~~percentage~~ dollar amount distributed to each training site; and

(3) ~~the average cost per trainee and a detailed breakdown of the components of these costs;~~

~~(4) other state or federal appropriations received for the purposes of clinical training;~~

~~(5) other revenue received for the purposes of clinical training; and~~

~~(6)~~ other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training.

The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

(f) The commissioner is authorized to distribute funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the department of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the trust fund.

(g) The advisory committee shall continue to study and make recommendations on:

(1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and

(2) the costs and benefits associated with medical education and research.

Sec. 7. Minnesota Statutes 1997 Supplement, section 62J.69, is amended by adding a subdivision to read:

Subd. 4. [TRANSFERS FROM THE COMMISSIONER OF HUMAN SERVICES.] (a) The amount transferred according to section 256B.69, subdivision 5c, shall be distributed to qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainees and the total statewide average costs per trainee, by type of trainee, in each program; and

(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the trust fund pool.

In this formula, the education factor shall be weighted at 50 percent and the public program volume factor shall be weighted at 50 percent.

(b) Public program revenue for the formula in paragraph (a) shall include revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care.

(c) Training sites that receive no public program revenue shall be ineligible for payments from the prepaid medical assistance program transfer pool.

Sec. 8. Minnesota Statutes 1997 Supplement, section 62J.69, is amended by adding a subdivision to read:

Subd. 5. [REVIEW OF ELIGIBLE PROVIDERS.] (a) Provider groups added after January 1, 1998, to the list of providers eligible for the trust fund shall not receive funding from the trust fund without prior evaluation by the commissioner and the medical education and research costs advisory committee. The evaluation shall consider the degree to which the training of the provider group:

(1) takes place in patient care settings, which are consistent with the purposes of this section;

(2) is funded with patient care revenues;

(3) takes place in patient care settings, which face increased financial pressure as a result of competition with nonteaching patient care entities; and

(4) emphasizes primary care or specialties, which are in undersupply in Minnesota.

Results of this evaluation shall be reported to the legislative commission on health care access. The legislative commission on health care access must approve funding for the provider group prior to their receiving any funding from the trust fund. In the event that a reviewed provider group is not approved by the legislative commission on health care access, trainees in that provider group shall be considered ineligible trainees for the trust fund distribution.

(b) The commissioner and the medical education and research costs advisory committee may also review provider groups, which were added to the eligible list of provider groups prior to January 1, 1998, to assure that the trust fund money continues to be distributed consistent with the purpose of this section. The results of any such reviews must be reported to the legislative commission on health care access. Trainees in provider groups, which were added prior to January 1, 1998, and which are reviewed by the commissioner and the medical education and research costs advisory committee, shall be considered eligible trainees for purposes of the trust fund distribution unless and until the legislative commission on health care access disapproves their eligibility, in which case they shall be considered ineligible trainees.

Sec. 98. [REPORT BY THE UNIVERSITY OF MINNESOTA ACADEMIC HEALTH CENTER.]

The University of Minnesota academic health center, after consultation with the health care community and the medical education and research costs advisory committee, is requested to report to the commissioner of health and the legislative commission on health care access by January 15, 1999, on plans for the strategic direction and vision of the academic health center. The report shall address plans for the ongoing assessment of health provider workforce needs; plans for the ongoing assessment of the educational needs of health professionals and the implications for their education and training programs; and plans for ongoing, meaningful input from the health care community on health-related research and education programs administered by the academic health center.

Sec. 106. [MEDICAL EDUCATION AND RESEARCH TRUST FUND STUDY.]

The commissioner of health shall review the current medical education and research costs advisory committee structure and composition and recommend methods to ensure balanced and appropriate representation of major training programs. The commissioner shall also review the statutory formula for the prepaid medical assistance carve out to determine if any adjustments should be made to correct existing or potential inequities on current training programs. The commissioner shall determine if there should be other criteria for weighting future distributions of medical education and research funds beyond the current statutory criteria, including the criteria that trainees continue to practice in Minnesota. The commissioner shall report the findings and recommendations to the legislative commission on health care access by December 15, 1998.

APPENDIX C

1998 MERC ADVISORY COMMITTEE MEMBERS
Department of Health
Health Economics Program

James Toscano, Chair, HealthSystem Minnesota
John Abenstein, Mayo Clinic
Peter Benner, AFSCME
Kent Crossley, Veterans Affairs Medical Center
Byron Crouse, University of Minnesota-Duluth School of Medicine
James Davis, St. Cloud Hospital
Sandra Edwardson, University of Minnesota School of Nursing
Thomas Elliott, Duluth Clinic
William Gold, Blue Cross Blue Shield of Minnesota
William Goodall, Allina Health System
David Herman, Mayo Clinic
William Jacott, University of Minnesota Medical School
Jim Kohrt, Cargill Corporation
Louis Ling, Hennepin County Medical Center
Dawn Ludwig, Augsburg College Physician Assistant Program
Gregg McPherson, 3M Center
Kathleen Meyerle, Mayo Clinic
Robert Mulhausen, HealthPartners Institute for Medical Education
Eric Netteberg, Preferred One
Frank Nuttall, Veterans Affairs Medical Center
Delwin Ohrt, Consumer Representative
Peter Rapp, Fairview University Medical Center
Marilyn Speedie, University of Minnesota College of Pharmacy
Michael Till, University of Minnesota School of Dentistry
Catherine Wisner, Diversified Pharmaceutical Services

APPENDIX D

1997 MERC ELIGIBILITY SUBCOMMITTEE MEMBERS
Department of Health
Health Economics Program

John Abenstein, Subcommittee Chair, Mayo Graduate School of Medicine
Don Berglund, Fairview University
Mike Berthelsen, University of Minnesota
John Bloom, Regions Hospital
Byron Crouse, University of Minnesota Duluth, School of Medicine
Jim Davis, St. Cloud Hospital
Sandra Edwardson, University of Minnesota School of Nursing
William Fehrenbach, HealthPartners
Thomas Franzen, HealthPartners
Betsy Getaz, Planned Parenthood
Scott Giebink, University of Minnesota Medical School
Cindy Goff Johnson, Blue Cross Blue Shield
Marsha Hall, Mayo Foundation
Joe Heidkamp, Fairview
Tom Hughes, Medical Alley
Frank Iossi, Mayo Foundation
William Jacott, University of Minnesota Medical School
Katherine Johnston, University of Minnesota Academic Health Center
Jim Kohrt, Cargill
Rich Korman, Minnesota Hospital Healthcare Partnership
David Lee, Minnesota Hospital Healthcare Partnership
Louie Ling, Hennepin County Medical Center
Dawn Ludwig, Augsburg College Physician Assistant Program
Nicholas Molitor, University of Minnesota School of Dentistry
Christine Mueller, MN Partnership for Training
Robert Mulhausen, HealthPartners
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Trisha Schirmers, Allina Health System
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Alaine Siniff, University of Minnesota Academic Health Center
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Tom Syverson, Hennepin County Medical Center
Michael Till, University of Minnesota School of Dentistry
James V. Toscano, MERC Advisory Committee Chair, Health System Minnesota
Vic Vikmanis, University of Minnesota Academic Health Center
Denise Wilson, University of Minnesota School of Dentistry

APPENDIX E

Health Policy & Systems Compliance

Medical Education and Research Costs (MERC)

Health Economics Program (HEP)

Please note, as of April 15, the MERC Online area of our web site is currently being updated for the 1998 application process. Please check back in the coming weeks for new and revised information.

Welcome to MERC Online. The MERC Trust Fund was established in 1996, and was funded for the first time in 1997, by the Minnesota Legislature, with the strong support of the Governor. Its purpose is to provide support for certain medical education and research activities in Minnesota that have historically been supported in significant part by patient care revenues. Our intent by creating this web site is to allow you easy access to information about MERC, help with the application process, and a method to contact HEP staff who work on the MERC Trust Fund Project.

Changes to this page will occur with regular frequency as more information comes online. For those of you with an active interest in MERC we invite you to bookmark this page in your browser and return here often for updated information. We thank you for you interest in the MERC Trust Fund and encourage you to use the information provided below.

- Basic Information about MERC.
- Trust Fund Application Information.
  - Frequently Asked Questions
  - Question 7 Spreadsheet for Download
  - List of Hospital Contacts for Question 9
  - List of the Percentage of Hospital Inpatient Costs Attributable to Medical Education Under MA and GAMC (for Question 9)
  - MA Provider Number List (now available on diskettes)
- Definitions of MERC terms and concepts.
- Schedule of Meetings **Coming soon for 1998**

- MERC Distribution Process: Formula and example of distribution method.
- MERC Legislative Summary
- MERC 1996 Report to the Legislature
- MERC 1997 Report to the Legislature

For other questions about the MERC Trust Fund, you may contact Health Economics Program staff at merc@health.state.mn.us.

Ordering HEP Publications

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For other questions about the Health Economics Program, please contact the Minnesota Department of Health's Health Policy & Systems Compliance Division, Health Economics Program at 612-282-5601, or by e-mail at hep@health.state.mn.us.

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For questions about the Health Policy & Systems Compliance Division, please contact: hpsc@health.state.mn.us

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